SEND ORIGINAL TO: INDUSTRIAL COMMISSION, JUDICIAL DIVISION, P.O. BOX 83720, BOISE, IDAHO 83720-0041

WORKERS' COMPENSATION COMPLAINT

CLAIMANT'S (INJURED WORKER) NAME AND ADDRESS TELEPHONE NUMBER:		CLAIMANT'S ATTORNEY'S NAME, ADDRESS, AND TELEPHONE NUMBER
EMPLOYER'S NAME AND ADDRESS (at time of injury)		WORKERS' COMPENSATION INSURANCE CARRIER'S (NOT ADJUSTOR'S) NAME AND ADDRESS
CLAIMANT'S SOCIAL SECURITY NO.	CLAIMANT'S BIRTHDATE	DATE OF INJURY OR MANIFESTATION OF OCCUPATIONAL DISEASE
STATE AND COUNTY IN WHICH INJURY OCCURRED		WHEN INJURED, CLAIMANT WAS EARNING AN AVERAGE WEEKLY WAGE OF: $_____, PURSUANT TO IDAHO CODE § 72-419

DESCRIBE HOW INJURY OR OCCUPATIONAL DISEASE OCCURRED (WHAT HAPPENED)

NATURE OF MEDICAL PROBLEMS ALLEGED AS A RESULT OF ACCIDENT OR OCCUPATIONAL DISEASE

WHAT WORKERS' COMPENSATION BENEFITS ARE YOU CLAIMING AT THIS TIME?

DATE ON WHICH NOTICE OF INJURY WAS GIVEN TO EMPLOYER	TO WHOM NOTICE WAS GIVEN

HOW NOTICE WAS GIVEN: ☐ ORAL ☐ WRITTEN ☐ OTHER, PLEASE SPECIFY

ISSUE OR ISSUES INVOLVED

DO YOU BELIEVE THIS CLAIM PRESENTS A NEW QUESTION OF LAW OR A COMPLICATED SET OF FACTS? ☐ YES ☐ NO IF SO, PLEASE STATE WHY.

NOTICE: COMPLAINTS AGAINST THE INDUSTRIAL SPECIAL INDEMNITY FUND MUST BE IN ACCORDANCE WITH IDAHO CODE § 72-334 AND FILED ON FORM I.C. 1002

PHYSICIANS WHO TREATED CLAIMANT (NAME AND ADDRESS)

WHAT MEDICAL COSTS HAVE YOU INCURRED TO DATE?

WHAT MEDICAL COSTS HAS YOUR EMPLOYER PAID, IF ANY? $ WHAT MEDICAL COSTS HAVE YOU PAID, IF ANY? $

I AM INTERESTED IN MEDIATING THIS CLAIM, IF THE OTHER PARTIES AGREE. ☐ YES ☐ NO

DATE	SIGNATURE OF CLAIMANT OR ATTORNEY: _____ TYPE OR PRINT NAME: _____

PLEASE ANSWER THE SET OF QUESTIONS IMMEDIATELY BELOW
ONLY IF CLAIM IS MADE FOR DEATH BENEFITS

NAME AND SOCIAL SECURITY NUMBER OF PARTY FILING COMPLAINT	DATE OF DEATH	RELATION TO DECEASED CLAIMANT

WAS FILING PARTY DEPENDENT ON DECEASED?	DID FILING PARTY LIVE WITH DECEASED AT TIME OF ACCIDENT?
☐ YES ☐ NO	☐ YES ☐ NO

CLAIMANT MUST COMPLETE, SIGN AND DATE THE ATTACHED MEDICAL RELEASE FORM

CERTIFICATE OF SERVICE

I hereby certify that on the ____ day of _____, 20___, I caused to be served a true and correct copy of the foregoing Complaint upon:

EMPLOYER'S NAME AND ADDRESS

_____

_____

_____

via: ☐ **personal service of process**

☐ **regular U.S. Mail**

SURETY'S NAME AND ADDRESS

_____

_____

_____

via: ☐ **personal service of process**

☐ **regular U.S. Mail**

_____
Signature

_____
Print or Type Name

NOTICE: An Employer or Insurance Company served with a Complaint must file an Answer on Form I.C. 1003 with the Industrial Commission within 21 days of the date of service as specified on the certificate of mailing to avoid default. If no answer is filed, a Default Award may be entered!

Further information may be obtained from: Industrial Commission, Judicial Division, P.O. Box 83720, Boise, Idaho 83720-0041 (208) 334-6000.

(COMPLETE MEDICAL RELEASE FORM ON PAGE 3)

Patient Name:_____

Birth Date:_____

Address:_____

Phone Number:_____

SSN or Case Number:_____

(Provider Use Only)

Medical Record Number:_____

□ **Pick up Copies** □ **Fax Copies #**_____

□ **Mail Copies**

ID Confirmed by:_____

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

I hereby authorize _____ **to disclose health information as specified:**

Provider Name – must be specific for each provider

To:_____

Insurance Company/Third Party Administrator/Self Insured Employer/ISIF, their attorneys or patient's attorney

_____

Street Address

_____

City **State** **Zip Code**

Purpose or need for data:_____

(e.g. Worker's Compensation Claim)

Information to be disclosed: **Date(s) of Hospitalization/Care:**_____

- ❑ **Discharge Summary**
- ❑ **History & Physical Exam**
- ❑ **Consultation Reports**
- ❑ **Operative Reports**
- ❑ **Lab**
- ❑ **Pathology**
- ❑ **Radiology Reports**
- ❑ **Entire Record**
- ❑ **Other: Specify**_____

I understand that the disclosure may include information relating to (check if applicable):

- ❑ **AIDS or HIV**
- ❑ **Psychiatric or Mental Health Information**
- ❑ **Drug/Alcohol Abuse Information**

I understand that the information to be released may include material that is protected by Federal Law (45 CFR Part 164) and that the information may be subject to redisclosure by the recipient and no longer be protected by the federal regulations. I understand that this authorization may be revoked in writing at any time by notifying the privacy officer, except that revoking the authorization won't apply to information already released in response to this authorization. I understand that the provider will not condition treatment, payment, enrollment, or eligibility for benefits on my signing this authorization. Unless otherwise revoked, this authorization will expire upon resolution of worker's compensation claim. Provider, its employees, officers, copy service contractor, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized by me on this form and as outlined in the Notice of Privacy. My signature below authorizes release of all information specified in this authorization. Any questions that I have regarding disclosure may be directed to the privacy officer of the Provider specified above.

_____

Signature of Patient **Date**

_____

Signature of Legal Representative & Relationship to Patient/Authority to Act **Date**

_____

Signature of Witness **Title** **Date**